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Shifting and Seizing: A Call to Reform Ohio's Outdated Restrictions on Drivers with Epilepsy

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SHIFTING AND SEIZING: A CALL TO REFORM OHIO'S OUTDATED RESTRICTIONS ON DRIVERS WITH EPILEPSY

KATHRYN KRAMER

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I. INTRODUCTION

On Monday, July 30, 2007, Chief Justice John Roberts, Jr. fell as a result of a benign idiopathic seizure.¹ This was Roberts's second seizure,² the first occurring approximately fourteen years earlier.³ In response to this incident and upon the advice of his physician, Roberts voluntarily limited certain activities, such as driving, until he and his physician felt confident that he could resume his daily routine without further seizures.⁴ Justice Roberts's self-imposed driving restriction did not

¹ Bill Mears & Jeanne Meserve, *Chief Justice Tumbles After Seizure*, CNN.COM, Jul. 31, 2007, <http://www.cnn.com/2007/US/law/07/30/roberts.fall/index.html>.

² Because Chief Justice Roberts has experienced more than one seizure, he is diagnosed with a seizure disorder, or epilepsy. *See infra* note 17.

³ Mears & Meserve, *supra* note 1, at ¶ 10.

⁴ *Id.* at ¶ 9.

provoke a significant public reaction,⁵ but many individuals with epilepsy do not enjoy the freedom to choose whether to drive, due to certain laws and policies that impose mandatory driving restrictions upon them with limited exceptions.⁶

[T]he duration of time between the two incidences indicated that Roberts is still capable of performing his duties. However, the next few months will be critical to see if he has another incident. That's because the duration of time between his seizures impacts upon the ability to do his job.

Langer said, "The more repetitive seizures a person has, the more problematic they become."

The chief justice's prognosis is actually not bad, according to Dr. Ron Alterman, neurosurgeon and director of Functional and Restorative Surgery at Mount Sinai Hospital. "It's better than if this were his first seizure. He has demonstrated that he will have seizures and they are not of a serious nature."

Alterman did say that age is always a factor in any workup. In Roberts' case, the fact that he is 52-years-old does put him at risk for certain conditions like embolic stroke in which a blood clot breaks off from the heart or the carotid artery and travels to brain. However, there is currently no indication of this.

In addition to the MRI, Roberts' doctors undoubtedly performed a spinal tap to rule out infections like meningitis, an inflammation of the membranes covering the brain and the spinal chord, and encephalitis, an inflammation of the brain. A spinal tap would also be used to rule out metabolic derangements like hypoglycemia and low sodium.

Roberts will probably not have to take medication, the doctors said. Anti-epileptic medications are reserved for serious repetitive seizures. However, he may have certain activities restricted as he did in 1993. At that time, his doctors temporarily restricted his diving.

This is typical, said Alterman. "Activities such as driving, diving, or flying a plane are restricted because a sudden loss of consciousness would pose a danger to Justice Roberts and others," he added.

Dr. Manny Alvarez, *What May Have Caused Chief Justice Roberts' Seizure*, FOXNEWS.COM, ¶¶ 6-12, Jul. 31, 2001, <http://www.foxnews.com/story/0,2933,291473,00.html>.

⁵ See, e.g., Elaine Cassel, Chief Justice Roberts's Health, After His Recent Seizure: What We Know, What We Don't Know, and What We May Never Know, FINDLAW'S WRIT, Aug. 2, 2007, <http://writ.news.findlaw.com/cassel/20070802.html>.

Presumably, Roberts has a Maryland driver's license. If so, when he renews it, Maryland (like most states) will require him to disclose any seizure disorder and to be seizure-free for three months. The Maryland Division of Motor Vehicles may also require proof that Roberts is taking medication.

In 1993, the year of his first seizure, Roberts reportedly had a colleague drive him to work for three months. While Roberts never told the driver the reason he had employed him, it was a wise precaution to have taken, and one that was consistent with Maryland law.

Id. at ¶¶ 8-9.

⁶ See generally Epilepsy.com, Driving and the Law, http://www.epilepsy.com/epilepsy/rights_driving (last visited Feb. 10, 2008) [hereinafter Epilepsy.com, *Driving and the Law*] (fifty state survey of state imposed driving restrictions).

Driving restrictions upon individuals with epilepsy date back as far as 1906.⁷ While the legislative intent of such restrictions is often unstated, it is likely that the restrictions were enacted to protect the general public from the perceived high risk of accidents caused by individuals with epilepsy.⁸ As a result of this assumption (whether or not correct), every state now mandates some type of driving restriction for drivers with epilepsy, and conditions the reinstatement of driving privileges upon seizure-free periods of specified durations and physician reports supporting the driving safety of the individual in question.⁹

Despite an arguably well-meaning legislative intent based on public safety,¹⁰ the driving restrictions on individuals with epilepsy are discriminatory. While the Ohio courts have determined the ability to drive is a privilege, not a legal right,¹¹ these laws restrict individuals with epilepsy from driving, despite an absence of scientific consensus that the risk of accidents caused by drivers with epilepsy is greater than that of individuals without epilepsy, or with any other medical condition.¹² Not all individuals with epilepsy are at risk of causing accidents,¹³ but the restrictions exhibit overbreadth by restricting the driving rights of all such individuals according to the

⁷ Richard S. McLachlan, *Medical Conditions & Driving: Legal Requirements & Approach of Neurologists*, 16 MED. & L. 269, 270 (1997). “Ever since the first reported automobile accident attributable to a seizure occurred in Germany in 1906, there have been legal restrictions placed on driving if a person has a seizure.” *Id.* at 270; *see also* John A. Devereux, *Epilepsy and Driving Licenses*, 21 MED. & L. 121, 125 (2002). After the influence of the EEG and anti-seizure medications, the strict prohibition on driving was reduced from a strict prohibition to a restriction in the 1940s. *See* Devereaux at 125.

⁸ M. C. Salinsky et al., *Epilepsy, Driving Laws, and Patient Disclosure to Physicians*, 33(3) EPILEPSIA 469, 469 (1992).

⁹ *Id.*

¹⁰ *Id.* at 471.

¹¹ *State v. Tanner*, 472 N.E.2d 689, 693 (Ohio 1984). “Driving is not a right but a privilege well within the purview of a state’s police powers.” *Id.*; *see also* *Breithaupt v. Abram*, 352 U.S. 432, 439 (1957); *State v. Starnes*, 254 N.E.2d 675, 679 (Ohio 1970). Thus, the state can eliminate the privilege to drive if there is a substantial state interest. *See Tanner*, 472 N.E.2d at 693.

¹² Laura K. Vogtle et al., *A Comparison of Physicians’ Attitudes and Beliefs Regarding Driving for Persons With Epilepsy*, 10(1) EPILEPSY AND BEHAVIOR 55, 55 (2007). *See also* Soham G. Sheth, et al., *Mortality in Epilepsy: Driving Fatalities vs. Other Causes of Death in Patients with Epilepsy*, 63 NEUROLOGY 1002 (2004); Devereux, *supra* note 7, at 125; McLachlan, *supra* note 7, at 274.

¹³ *See e.g.*, Epilepsy Foundation, *Causes of Epilepsy*, <http://www.epilepsyfoundation.org/about/types/causes/index.cfm> (last visited Feb. 10, 2008) [hereinafter Epilepsy Foundation, *Causes*]; *Ormond v. Garrett*, 175 S.E.2d 371, 372-74 (N.C. Ct. App. 1970) (holding that a driver with epilepsy should be permitted to drive because the administrative record was devoid of any significant evidence that motorist had no ability to exercise reasonable and ordinary control over a vehicle. Motorist’s seizures were medically controlled and he had driven approximately 75,000 miles without an incident over the course of three years); *Commonwealth v. Miller* 89 Pa.D & C 486, 488 (Pa.Comm.w.Ct. 1954) (holding that motorist was not prohibited from driving because motorist had warning headaches prior to a seizure and only had three seizures in eleven years, without incident).

most serious cases of epilepsy.¹⁴ Therefore, application of this discriminatory legislation exerts an undue burden upon individuals with epilepsy, including employment difficulties and diminished autonomy, without sufficient safeguards for individual assessment and choice.¹⁵

Ohio is gifted with flourishing medical and health law markets.¹⁶ Ohio's recognition and leadership in these areas may facilitate its reevaluation of the equity of epilepsy-based driving restrictions, and the state may take a prominent role in revising laws promoting patient rights while balancing those rights with public interest. With its progressive health market, Ohio should have comparably progressive health laws.

Presented herein is an analysis of the equity of epilepsy-related driving restrictions and the role that the state of Ohio may assume in the restructuring of such laws. Part two of this paper discusses the medical aspects of seizures and epilepsy, including basic etiology, treatments, and prognoses. Part three of this paper examines the different types of disabilities and the stigma that impacts individuals with epilepsy. Part four reviews the history of licensing and the Ohio Revised Code provisions that govern driving, licensing, and restrictions imposed upon individuals who have experienced seizures. Part five examines the Ohio case law that imposes a negligence standard upon individuals driving with epilepsy, similar to that of other medical conditions. Part six identifies the problems of the existing statutory and case law. Specifically, this discussion focuses on the lack of scientific evidence to provide an appropriate basis of the law, the inaccuracies of the current law, and the harm imposed by contemporary licensing restrictions on individuals with epilepsy. Part seven suggests improvements to the current law that may better balance the competing interests of public safety and individual autonomy. Finally, part eight proffers a recommendation that the state of Ohio establish driving restrictions only for individuals with epilepsy who pose a significant risk of harm to other drivers. Alternatively, if broad driving restrictions for individuals with epilepsy are to be maintained in support of public safety, this paper presents a recommendation for improving the equity of the legislative intent by extending such restrictions to cover other high-risk drivers with similar medical conditions that are, at present, not similarly restricted.

¹⁴ See *infra* notes 127-36.

¹⁵ See *infra* notes 51, 143-55.

¹⁶ See generally *Ohio Health-Care Startups Lead Midwest in Venture Capital Investments*, COLUMBUS BUSINESS FIRST, Aug. 16, 2007, <http://www.bizjournals.com/columbus/stories/2007/08/13/daily20.html> (last visited Feb. 10, 2008). Cleveland has two of the largest law firms in the country, Jones Day and Squire, Sanders & Dempsey, and is consistently high ranked. See generally City-data.com, Hot "Legal" Cities, <http://www.city-data.com/forum/general-u-s/134222-hot-legal-cities.html>. Cleveland also has two award-winning hospitals: Cleveland Clinic Foundation and University Hospitals. See U.S. News & World Report, America's Best Hospitals 2007 Index, http://health.usnews.com/usnews/health/best-hospitals/hosp_alph.htm (last visited Feb. 10, 2008); The Cleveland Clinic Foundation, <http://www.clevelandclinic.org/> (last visited Feb. 10, 2008); University Hospitals, <http://www.uhhospitals.org/> (last visited Feb. 10, 2008).

II. THE MEDICAL BACKGROUND

Epilepsy is clinically defined as the occurrence of more than one unprovoked seizure in a lifetime of an individual.¹⁷ A seizure is a “sudden attack” that results from an “abnormal electrical discharge in the brain.”¹⁸ Epilepsy can involve acute, recurring seizures¹⁹ that can vary in severity and frequency and may remain chronic for a lifetime or for a period of time.²⁰

The etiology of seizures and epilepsy varies for each individual.²¹ Some individuals develop chronic epilepsy, while others only experience one isolated seizure.²² The potential causes include congenital abnormalities, antenatal or perinatal factors, infectious conditions such as meningitis, and physical trauma.²³ A seizure may be triggered by any combination of triggering factors, such as environment, biology, genetics, and physical impairments.²⁴ The most common of the potential causes is physical head trauma; however, the trauma need not be extensive, and a seizure disorder can develop months after the initial trauma.²⁵ Most seizures consist of different features, such as loss of consciousness, involuntary muscle spasms or abnormal sensations; however, these features may vary, making seizures “almost infinite in variety as viewed by any observer.”²⁶

¹⁷ EpilepsyFoundation.org, What is Epilepsy, <http://www.epilepsyfoundation.org/about/index.cfm> (last visited Feb. 10, 2008) [hereinafter Epilepsy Foundation, *What is Epilepsy*].

¹⁸ Merriam-Webster.com, Definition of Seizure, <http://www2.merriam-webster.com/cgi-bin/mwmednlm?book=Medical&va=seizure> (last visited Feb. 10, 2008); see also Brief of the Epilepsy Foundation of America as Amicus Curiae in Support of Respondent Barbara J. Elkin, School Board of Nassau County v. Arline, 107 S. Ct. 1123 (1986) (No. 85-1277), 1986 WL 728014, *FN 6 [hereinafter Epilepsy Foundation, *Amicus Curiae*].

¹⁹ Epilepsy Foundation, *Causes*, *supra* note 13, at ¶ 6.

²⁰ *Id.*

²¹ Brenda Patoine, *Unraveling Epileptogenesis: Research Yields Clues to How Epilepsy Develops, Progresses*, EPILEPSYUSA, September/October 2007, <http://www.epilepsyfoundation.org/epilepsyusa/magazine/septoct07/epileptogenesis-p1.cfm> (last visited Feb. 10, 2008); see generally EpilepsyUSA Staff, *New Epilepsy Guidelines Will Improve Treatment, Access: Current Treatment Often Relies on 10-Year-Old Data, Excludes Newer Drugs*, EPILEPSY FOUNDATION.COM, Apr. 18, 2004, <http://www.epilepsyfoundation.org/epilepsyusa/guidelines2004.cfm> [hereinafter Epilepsy USA, *Excludes Newer Drugs*]. “Epilepsy is not a one size fits all disorder.” Epilepsy USA, *Excludes Newer Drugs*, at ¶ 2.

²² Patoine, *supra* note 21, at ¶ 1.

²³ Epilepsy Foundation, *Causes*, *supra* note 13, at ¶¶ 7-8.

²⁴ ROSCOE L. BARROW & HOWARD D. FABING, M.D., *EPILEPSY AND THE LAW* 15-17 (1966).

²⁵ Epilepsy Foundation, *Causes*, *supra* note 13, at ¶ 7.

²⁶ BARROW & FABING, *supra* note 24, at 11.

The movement to liberalize driving restrictions for persons with epilepsy gained support from the 1956 publication of a seminal book by Barrow and Fabing on the legal affects of epilepsy. This comprehensive work considered the issue of driving and epilepsy and proposed that more liberal attitudes toward driving by persons with controlled seizures were reasonable and appropriate.

There is no cure for epilepsy, but it can often be controlled and treated.²⁷ Traditional treatments include drug therapies, such as Dilantin or Lamictal, and psychosurgery,²⁸ but the details depend on the type, severity, and frequency of the seizures.²⁹ Because many therapeutic options exist, physicians and patients may

Allan Krumholz, *Driving and Epilepsy: A Historical Perspective and Review of Current Regulations*, 35(3) EPILEPSIA 668, 668 (1994).

²⁷ EpilepsyFoundation.org, Treatment, <http://www.epilepsyfoundation.org/about/treatment/> (last visited Feb. 10, 2008) [hereinafter Epilepsy Foundation, *Treatment*].

²⁸ *Id.* Other non-traditional treatments exist such as Vagus nerve stimulation (VNS) (designed to prevent seizures with electrical energy sent to the brain via the vagus nerve, supplied by a pacemaker-like device), Dietary Therapies (ketogenic diet with high fat and low carbohydrates used in conjunction with anti-epileptic medication), and Non-Drug Therapies (Art Therapy or Herbal Medications). See generally Epilepsy.com, Treatment 101: The Basics, http://www.epilepsy.com/101/101_treatment (last visited Feb. 10, 2008) [hereinafter Epilepsy.com, *Treatment 101*].

²⁹ Epilepsy Foundation, *Treatment*, *supra* note 27; see also EpilepsyFoundation.org, Specific Medicines, <http://epilepsyfoundation.org/answerplace/Medical/treatment/medications/typesmedicine/> (last visited Feb. 10, 2008).

There are currently four treatment options for epilepsy - antiepileptic medication, dietary modification (the ketogenic diet), vagal nerve stimulation, and epilepsy surgery. The majority of patients with epilepsy are treated with anti-seizure medication. Presently, there are a total of 15 antiepileptic medications available for use. These agents vary in terms of their mechanism of action (the specific effects of each drug on nerve cells). Due to differences in the mechanism of action, certain medications may be more effective than others in treating particular seizure types. However, there is no "superstar" among these 15 antiepileptic medications. In other words, there is no one medication that stands far and away above the rest in terms of effectiveness in treating seizures. The major factor that separates these antiepileptic medications from each other is their side effects.

The antiepileptic medications can be divided into two major groups. The "old" antiepileptic drugs were released for use prior to 1978. Those medications consist of phenobarbital, Dilantin, Mysoline, Klonopin, Zarontin, Tegretol and Depakote. There was a 15-year period from 1978 to 1993, where no new anti-seizure drugs were approved for use. Since 1993, an additional 8 medications have been granted approval by the FDA. These are the "new" anti-seizure medications and consist of Felbatol, Neurontin, Lamictal, Topamax, Gabitril, Trileptal, Zonegran, and Keppra. As a general rule, the "old" medications tend to be more sedating than the new ones, and tend to cause more drug interactions. In other words, these older medications can often alter the effectiveness and the blood levels of medications patients may be taking for other conditions (such as diabetes, hypertension, and heart disease). In addition, the older medications, as a group, are more likely to cause disruptions of liver function and alterations of blood counts. The new medications, as a group, tend to be less sedating. They have fewer drug interactions and are more compatible with other medications that patients may be taking. The new drugs, therefore, as a group, are not necessarily more effective to control seizures, however they are somewhat safer, better tolerated, and easier to use than the older drugs.

In determining which medication is best for an individual patient, several factors must be taken into account. The particular type of epilepsy the patient has is very important. Some anti-seizure medications may be effective against only a few seizure types or

discuss the options and adjust the regime over a significant period of time to find a particular drug and dosage with minimal side effects and high effectiveness.³⁰ Because surgery is a more invasive option, it is typically used only when drug therapies are unsuccessful in reducing debilitating and chronic seizures.³¹

In determining how a patient should be treated for seizures, physicians take several factors into account: the patient's EEG,³² a history of seizure activity,

one seizure type, whereas other medications (the so-called broad spectrum agents) may be effective against multiple seizure types. Therefore, the type of epilepsy is important for the physician to consider before choosing the proper medication for an individual patient.

Side effects of antiepileptic medications vary tremendously. Some medications are likely to produce weight gain, others weight loss. Certain medications may be more sedating than others and some medications are more likely to affect thought processing and speech. Although, as a group, the newer medications have fewer drug interactions, there are still some important interactions for the physician to consider in choosing the proper medication.

For example, some, but not all, of the newer anti-seizure medications may reduce the effectiveness of birth control pills. There are differences in how the various anti-seizure medications are eliminated by the body. For example, some of the anti-seizure medications are eliminated solely by the liver, others are eliminated primarily through the kidneys, and others may be eliminated by a combination of liver and kidney.

Therefore, the presence or absence of underlying liver or kidney disease may be important in deciding which anti-seizure medication would best suit an individual patient. The anti-seizure medications may also have different effects on mood. For example, some of the newer agents have a positive effect on mood, whereas others may have a negative effect (in some patients causing increased levels of anxiety, irritability, or even depression). Therefore, in choosing a medication for an individual patient, the physician must take into account the patient's age, their sex, their occupation, whether or not they have an underlying psychologic disorder (such as anxiety or depression), what other medications they may be taking, their body weight, and whether or not they have any underlying kidney or liver dysfunction.

In addition to the above considerations, some antiepileptic medications (primarily the older medications) may have a negative effect on bone health, making patients more prone to the development of osteoporosis and therefore increasing the risk of fracture, should they fall.

Kenneth R. Murray, *Treatment Options for Epilepsy - Selection of the Best Antiepileptic Medications*, DENT NEUROLOGICAL INSTITUTE, ¶¶ 1-7, Jul. 2004, http://www.dent.institute.com/news_179.html (last visited Feb. 10, 2008).

³⁰ Epilepsy Foundation, *Treatment*, *supra* note 27.

³¹ EpilepsyFoundation.org, *Treatment Options: Surgery*, <http://epilepsyfoundation.org/about/treatment/surgery/index.cfm> (last visited Feb. 10, 2008).

³² BARROW & FABING, *supra* note 24, at 19-20. In 1929, Has Berger developed an electroencephalogram ("EEG") as a means of measuring brain waves, in hopes to measure electrical currents in the brain. Electrodes are placed on the scalp and electrical wave patterns are recorded. Some individuals with epilepsy have what is known as a spike, or a concentrated, abnormal amount of electrical energy, on an electroencephalogram ("EEG"). While this pattern is abnormal, not all epilepsy patients have an abnormal EEG. *Id.*

whether or not the individual is a driver, the age of the individual, and any other neurological disorders experienced by the individual.³³ Physicians typically choose not to instigate a treatment plan for individuals who are very young, have no previous history of neurological disorders or seizures, or have only experienced one seizure, because the risk of a repeat incident is small in relation to the high risk of negative side effects from anti-seizure medication.³⁴

For individuals with epilepsy who are prescribed drug therapies, medication can be successful in preventing seizures if taken as directed.³⁵ Antiepileptic medication

The EEG shows patterns of normal or abnormal brain electrical activity. Some abnormal patterns may occur with a number of different conditions, not just seizures . .

.. Certain other patterns indicate a tendency toward seizures. Your doctor may refer to these waves as "epileptiform abnormalities" or "epilepsy waves." These include spikes, sharp waves, and spike-and-wave discharges. Spikes and sharp waves in a specific area of the brain, such as the left temporal lobe, indicate that partial seizures might possibly come from that area. Primary generalized epilepsy, on the other hand, is suggested by spike-and-wave discharges that are widely spread over both hemispheres of the brain, especially if they begin in both hemispheres at the same time.

Epilepsy.com, EEG, ¶¶ 3-4, http://www.epilepsy.com/epilepsy/testing_eeg (last visited Feb. 10, 2008). In addition to determining whether there is abnormal brain activity through an EEG, physicians will also conduct a thorough physical examination, including laboratory tests, to determine whether all your organs are operating properly. See generally Epilepsy.com, Physical Exam, http://www.epilepsy.com/epilepsy/testing_exam (last visited Feb. 10, 2008).

³³ Epilepsy Foundation, *Treatment*, *supra* note 27.

³⁴ *Id.*

[Physicians may chose not to treat a single seizure incident] because studies show that an otherwise normal child who has had a single seizure has a relatively low (15%) risk of a second one. Once the second has occurred, the risk of subsequent seizures is substantially increased.

On the other hand, the risk of another seizure for a child who is neurologically abnormal, or whose EEG is abnormal, may be as high as 50-60%.

In determining whether to treat, physicians consider the risk-benefit ratio, which varies according to the age of the patient and his or her activity level. Waiting to see whether another generalized tonic-clonic seizure occurs is less risky for a child living in a sheltered home environment than it is for a salesman who lives most of his life driving a car, or an elderly person with brittle bones. On the other hand, antiepileptic drugs have side effects which, while generally mild, can in some cases include liver damage and potentially fatal rashes and blood disorders. Thus the decision to treat becomes a highly individualized one in which the risks of the treatment are weighed against the risks of the seizures.

Id. at ¶¶ 3-5.

³⁵ See EpilepsyFoundation.org, Treatment Options: Medication, <http://www.epilepsyfoundation.org/about/treatment/medications/index.cfm> (last visited Feb. 10, 2008) [hereinafter Epilepsy Foundation, *Medication*]. Not taking the medication as directed (taking too few; taking too much) will affect the levels of medication in the blood stream and can cause additional seizures. *Id.* However, it is also important that physicians not focus only on treating seizures, but the disorder in totality. See also Epilepsy USA, *Excludes Newer Drugs*, *supra* note 21, at ¶ 1.

is effective for the majority of individuals; by one estimate, at least fifty percent of patients with epilepsy can effectively control their disorder with anti-seizure medication, while nearly thirty percent experience a significant decrease in the frequency of seizures.³⁶ Due to the high effectiveness of medications, individuals with epilepsy who are prescribed medication and follow treatment programs are likely to have a good prognosis.

III. DISABILITIES AND STIGMA OF EPILEPSY

Epilepsy globally affects approximately between forty-four and one hundred per one hundred thousand people per year,³⁷ and nearly three million people in the United States.³⁸ Despite the relatively common nature of epilepsy, afflicted individuals have historically been burdened by social stigma.³⁹ Prior to medical advancements, seizures were believed to be associated with demonic possession and negative religious experiences.⁴⁰ People with epilepsy were often shunned or isolated out of fear or intolerance.⁴¹ Until the 1950s, individuals with epilepsy were legally

But if [the patient] is also walking around in a fog or can't go to school or can't work or has memory problems because of the medication, then that's not treating the patient, that's only treating the seizures. It's important that everything that is going on in the patient's life be clinically evaluated.

Id. at ¶ 8.

³⁶ Epilepsy Foundation, *Amicus Curiae*, *supra* note 18, at *FN 6. *See also supra* note 35.

³⁷ Robert S. Fisher et al., *The impact of epilepsy from the patient's perspective*, 41(1) EPILEPSY RESEARCH 39 (2000).

³⁸ EpilepsyFoundation.org, About Epilepsy, <http://www.epilepsyfoundation.org/about/> (last visited Feb. 10, 2008) [hereinafter Epilepsy Foundation, *About*].

³⁹ *See* Epilepsy.com, Facts & Myths, http://www.epilepsy.com/101/ep101_facts (last visited Feb. 10, 2008) [hereinafter Epilepsy.com, *Facts & Myths*].

⁴⁰ Epilepsy Foundation, *Amicus Curiae*, *supra* note 18, at *7, FN 9; *see also* Kathy Lammert, *When Epilepsy Goes By Another Name*, EPILEPSY.COM, Sept. 15, 2003, http://www.epilepsy.com/articles/ar_1063680870.html. “The word ‘seizure’ is believed to derive from a notion that people with epilepsy are ‘seized’ by supernatural forces.” Fisher, *supra* note 37, at 49.

⁴¹ Epilepsy.com, *Facts & Myths*, *supra* note 39; *see also* Epilepsy Foundation, *Amicus Curiae*, *supra* note 18, at *4. “Epilepsy is not the only condition which carries with it a history of fear and misunderstanding. Persons with cancer, Hansen's Disease (leprosy), cerebral palsy and others have all been subject to discriminatory decisions based on prejudice and fear.” Epilepsy Foundation, *Amicus Curiae supra* note 18; FN 4. For example, in Scotland during the Middle Ages, men were castrated and pregnant women were buried alive for having epilepsy. In the eighteenth and nineteenth centuries, individuals with epilepsy were institutionalized and considered insane. *Id.* at 9; FN 14.

In the nineteenth century, persons with epilepsy were also considered mentally disturbed and potentially violent or homicidal. In 1848, the British Ministry of Labour issued a pamphlet which stated: [E]pileptics are commonly believed to be mentally imbalanced, dull, or frankly mentally defective, liable to progressive mental deterioration, awkward to live with, antisocial or potentially criminal, incurable, resistant to all forms of medicine, unemployable, and persons who should be sequestered in institutions.

denied the right to marry, the right to drive a car, and the right to obtain employment.⁴² Some were even subjected to involuntary sterilization to preclude reproduction.⁴³ It was not until 1982 that the last state repealed its law precluding individuals with epilepsy from marrying.⁴⁴

Today, the negative portrayal of epilepsy by the media continues to reinforce the public misperceptions and contribute to the stigma and social disability associated with epilepsy.⁴⁵ Many media stories contain inaccurate information about the cause and nature of epilepsy, as well as its treatment and long-term prognosis of individuals afflicted with the condition.⁴⁶ The media occasionally portrays individuals with epilepsy in an exaggerated manner, using “demonic imagery” and invoking exorcism concepts.⁴⁷

Individuals with epilepsy are often socially characterized by the disorder.⁴⁸ Despite being one of the oldest recognized medical conditions, epilepsy “is still surrounded by mystery, ignorance, and fear.”⁴⁹ In a survey of United States

Id. at *8, (citing Fox, *The Epileptic in Industry*, 11 BRITISH JOURNAL OF PHYSICAL MEDICINE 140-44 (1948)). “The person with epilepsy is most often far less handicapped in fact by his seizures than by society’s fear and misunderstanding of the disorder.” Epilepsy Foundation, *Amicus Curiae supra* note 18, at *6.

⁴² BARROW & FABING, *supra* note 24, at 1. Individuals with epilepsy were denied these rights, many of which are constitutionally declared fundamental rights. Seventeen states still had active involuntary sterilization laws applicable to individuals with epilepsy as late as 1955. *Id.* at 10. As of 1986, Delaware still reserved the right to involuntarily sterilize individuals with epilepsy. Epilepsy Foundation, *Amicus Curiae, supra* note 18, at *10, (citing DEL. CODE ANN. tit. 16 §57-01 *et seq.*, as amended, (1983)).

⁴³ BARROW & FABING, *supra* note 24, at 1.

⁴⁴ See MO. REV. STAT. §451.115 (Vernon 1986 Supp.), amended by L. 1982, p. 626 §1. For additional laws restricting the right to marry, see e.g. WASH. REV. CODE §26.04.230 (1951) (individuals with epilepsy fined and imprisoned for marriage).

These marriage statutes [such as the Washington statute] were originally enacted on the presumption that epilepsy was hereditary, progressively degenerating, and basically incurable. It was also believed that persons with epilepsy were less intelligent than the general population, and hence, prohibiting marriage and procreation was a method of social control over this feared condition.

Epilepsy Foundation, *Amicus Curiae, supra* note 18, at *10.

⁴⁵ Martha J. Morrell, *Stigma and Epilepsy*, 3 EPILEPSY & BEHAVIOR S21, S23 (2002); see also Dan Childs, *Roberts’ Seizure May Foster Awareness of Condition*, ABC NEWS.COM, Jul. 31, 2007, <http://www.abcnews.go.com/Health/story?id=3432352&page=1>.

⁴⁶ Morrell, *supra* note 45, at S23.

⁴⁷ *Id.* In order to illustrate the media misconceptions portrayed in a major motion picture, see THE EXORCISM OF EMILY ROSE (Lakeshore Entertainment 2005). See also The Internet Movie Database, The Exorcism of Emily Rose, <http://www.imdb.com/title/tt0404032/> (last visited Feb. 10, 2008). The tagline for the movie, “What happened to Emily?”, *id.* conveys a demonic possession that is not true of the disorder. This movie portrays a priest performing an exorcism on a young woman who is afflicted with epilepsy, which blurs the concepts for the uninformed viewer. *Id.*

⁴⁸ Epilepsy.com, *Facts & Myths, supra* note 39.

⁴⁹ Epilepsy USA, *Excludes Newer Drugs, supra* note 21, at ¶ 6.

teenagers, approximately half of the survey participants believed epilepsy to be contagious, half believed it to be a mental illness, and approximately two-thirds stated that they would not date an individual with epilepsy.⁵⁰ In addition to bearing the social stigma associated with the disorder, people with epilepsy statistically experience a lower rate of marriage, reduced educational success, and a high frequency of employment difficulties.⁵¹ As a class, individuals with epilepsy have

⁵⁰ *Id.*

⁵¹ See generally Morrell, *supra* note 45; Fisher, *supra* note 37.

Stigma effects epilepsy patients in a variety of ways. Lower marriage rates for men and women with epilepsy are partially attributable to stigma. Fisher et al. recently reported that 51% of men with epilepsy were married, in contrast to 63% of men without epilepsy. Likewise, only 48% of women with epilepsy were married, compared with 59% of women without epilepsy. Limited social opportunities contribute to lower birth rates among men and women with epilepsy.

Morrell, *supra* note 45, at S22. A similar study found similar results. "People with epilepsy have a lower rate of marriage. In a survey of 343 people seen at a seizure clinic, 33% of men over 20 years old were married, compared to 65% in the community. Among women, 46% with epilepsy and 73% in the community were married." Fisher, *supra* note 37, at 46. Individuals with epilepsy may have difficulties in school due to feeling left out and stigmatized socially by other students. In addition, educators may not understand the disorder and not adequately attend to students academically within the classroom. Medications and other treatments also may negatively affect the ability of the individual to learn. Epilepsy.com, Education, http://www.epilepsy.com/epilepsy/social_education (last visited Feb. 10, 2008).

Slightly more than half of the respondents graduated from high school and 15% graduated from college. Despite this relatively high rate of educational achievement, performance in school was singled out as an activity adversely affected by epilepsy, more so than job performance, driving a car, relationships with family, and even the overall quality of life. ... School performance can be impacted negatively by anti-seizure medications. ... Stigmatization by fellow students may also contribute to poor performance in school. In addition, students with epilepsy may harbor an awareness of underachievement relative to the own expectations. Cognitive impairment may reasonably be considered a component of impaired school performance. Children with epilepsy are at risk for learning problems and tend to be one year below expected reading levels. ... A Los Angeles study of children attending epilepsy clinics documented a 16% lower score for reading and 50% lower for general knowledge in children with epilepsy. A disproportionate share of children with epilepsy repeats grades or drop out of school. Therefore, although many of the respondents graduated from high [school] and college, they may not have done so as quickly or as easily as they would wish.

Fisher, *supra* note 37, at 46-7. Individuals with epilepsy often have difficulties finding suitable employment as a result of poor training from lack of education, discomfort of co-workers, and concerns of employers, including: safety at work, company liability worries, questions regarding individual's functionality, and the potential of scaring off customers if the individual were to have a seizure on the job. Epilepsy.com, Employment, http://www.epilepsy.com/epilepsy/social_employment (last visited Feb. 10, 2008) [hereinafter, Epilepsy.com, *Employment*]. "Employment discrimination is a reality for many individuals with epilepsy. Although the Americans with Disabilities Act (ADA) was initially thought to address many of the discriminatory employment practices adversely impacting persons with epilepsy, recent judicial rulings suggest that persons with epilepsy have little protection against unreasonable employment practices." Morrell, *supra* note 45, at S22.

unemployment rates as high as twenty-five percent.⁵² These individuals often lose their jobs in connection with a seizure at their workplace, due to the fear experienced by other employees as a result of the visually frightening seizure and the stigma associated with epilepsy.⁵³

Individuals with epilepsy often see themselves as “impaired in general health, mental health, vitality, and societal roles” in comparison to individuals without epilepsy.⁵⁴ Even individuals with mild cases of epilepsy report experiencing “psychological distress, loneliness, adjustment and coping, and stigma perception” as negative quality-of-life factors.⁵⁵ A majority of individuals first diagnosed with epilepsy react with fear, depression, and anger,⁵⁶ and many individuals feel a loss of self-confidence, embarrassment, or shame.⁵⁷

Perhaps the most dramatic social consequence to the individual of having a diagnosis of a seizure disorder is its effect on obtaining and maintaining employment. Unfortunately, all too often persons with epilepsy are denied employment or not trained for work they could do well and safely, because of an unreasoned fear of their seizures. The working community has not welcomed persons with epilepsy with open arms.

Epilepsy Foundation, *Amicus Curiae*, *supra* note 18, at *11.

[I]n 1979 six percent (6%) of the American population still objected to their children associating with persons with epilepsy, nine percent (9%) still believed persons with epilepsy should not be employed, three percent (3%) believed that epilepsy was a form of insanity, and nearly one out of five percent (18%) adults stated they would object to a son or daughter marrying a person with epilepsy.

Id., at *6-7.

The number of unemployed persons with epilepsy (among those fully able to work) remains disproportionately high. The Congressionally established Commission for the Control of Epilepsy and Its Consequences reported that the unemployment rate of this population is two to three times the national average. The underemployment rate, (i.e., persons employed in positions below their level of skill) remains even higher. In reviewing the many factors that might contribute to these high rates, the Commission identified employer attitudes toward hiring persons with epilepsy as a major barrier to achieving employment. Others have agreed with this view.

Id. at *11-12.

⁵² Epilepsy USA, *Excludes Newer Drugs*, *supra* note 21, at ¶ 5.

⁵³ *Id.*

⁵⁴ Fisher, *supra* note 37, at 48. Among other things, physicians often suggest that patients with epilepsy refrain from such activities as strenuous exercise, sports, taking a bath and swimming. The recommendation to refrain from these activities, especially the privilege of taking a bath without supervision, often creates a sense of dependency which can lead to a decreased feeling of autonomy. See generally The Cleveland Clinic, *Epilepsy Patient Guide* (2006), available at http://my.clevelandclinic.org/Documents/Epilepsy_Center/ep_guide.pdf.

⁵⁵ Morrell, *supra* note 45, at S23.

⁵⁶ Fisher, *supra* note 37, at 44.

⁵⁷ *Id.* at 44-5.

“There is an ongoing, significant embarrassment level about it,” said Dr. Orrin Devinsky, director of the Epilepsy Center at New York University. “The feeling, for a lot of people, is that it does carry a lot worse stigma than a cancer, or an H.I.V. even. At some level, it’s society that needs to wake up and realize it’s just another neurologic disorder.” Warren Lammert, who runs a financial firm in Boston and

IV. THE OHIO LICENSING STATUTES

The state of Ohio's enforcement of restricted driving rights for individuals with epilepsy begins with a disclosure requirement. When applying for a driver's license issuance or renewal in Ohio, an individual must comply with the Ohio Revised Code §4507.06(A)(1)(c)⁵⁸ requirement of disclosure under oath as to "whether the applicant is now or ever has been afflicted with epilepsy."⁵⁹ An individual who falsifies this application by not disclosing seizures is subject to prosecution under Ohio Revised Code § 2921.13.⁶⁰

In Ohio, like many states, a driver's privilege to drive⁶¹ may be denied, suspended or terminated for reason of "physical disability, where the basis therefore is the applicant's or holder's alleged affliction with a physical defect or disease of organic origin."⁶² Because driving is a privilege, a state administrative agency may only deny, suspend, revoke, or terminate a license based on a statute.⁶³ In the case of an applicant with epilepsy, the Ohio Bureau of Motor Vehicles typically cites Ohio

whose daughter has epilepsy, founded an organization in 2002 with Dr. Devinsky and two others to support research into new treatments. "It's better today," he said about public perceptions of the disorder. "But even among well-educated people, people don't like to talk about epilepsy." While many public figures with cancer (or cancer in the family) are forthcoming about the illness, Mr. Lammert said, the same does not go for epilepsy. And though his organization, the Epilepsy Therapy Development Project, has two strong public representatives — the Olympic women's hockey goaltender Chanda Gunn and the hip-hop artist D J Hapa — the disorder has never found an icon like Michael J. Fox, whose openness about Parkinson's disease helps raise tens of millions of dollars a year for research.

Aliyah Baruchin, *Battling Epilepsy and Its Stigma*, THE NEW YORK TIMES, Feb. 20, 2007, available at <http://www.nytimes.com/2007/02/20/health/20epil.html>.

⁵⁸ Form and contents of application for license; registration of voters, OHIO REV. CODE §4507.06(a)(1)(c) (2007). In addition, the applicant must also declare "whether the applicant now is suffering from any physical or mental disability or disease and, if so, the nature and extent of the disability or disease, giving the names and addresses of physicians then or previously in attendance upon the applicant." *Id.* However, the physical or mental disability or disease is restricted to current conditions, whereas epilepsy is restricted for having ever occurred. "Physical or mental disability or disease" is not defined within the statute. *Id.* But, it can be inferred that the legislature meant it only to relate to seizure-related incidents because all the case citations associated with this section refer only to accidents occurring from seizure-related incidents. Former O.R.C. § 4507.06 was repealed by 1986 H 428, which became effective on December 23, 1986, twenty years ago. There have been significant medical advances since the enactment of this law, yet no amendments have addressed this.

⁵⁹ *Id.*

⁶⁰ Falsification, OHIO REV. CODE § 2921.13 (2007). See Generally EpilepsyFoundation.org, Driver Information by State -- Ohio, <http://epilepsyfoundation.org/living/wellness/transportation/drivinglaws.cfm> (select "Ohio" from the dropdown box) (last visited Feb. 10, 2008) [hereinafter Epilepsy Foundation, *Ohio Driving Laws*].

⁶¹ See *supra* note 11.

⁶² William H. Danne, Jr., Annotation, *Denial, Suspension, or Cancellation of Driver's License Because of Physical Disease or Defect*, 38 A.L.R.3d 452 (1971).

⁶³ *Id.*

Revised Code § 4507.08(D)(3),⁶⁴ which permits the restriction of driving rights where the administrative agency has reason to believe that the driver “by reason of physical or mental disability would not be able to operate a motor vehicle with safety upon the highways.”⁶⁵ Pursuant to Ohio Revised Code § 4507.08(D)(3), the driving rights of a person with epilepsy are subject to a medical suspension because this physical disability prevents reasonable and ordinary control of a motor vehicle.⁶⁶

A license suspended due to a driver’s epileptic condition may be reinstated by the Bureau of Motor Vehicles only after the driver receives medical clearance from a physician.⁶⁷ The physician’s sworn statement indicates that the “person’s condition either is dormant or is under effective medical control, and that the control has been maintained continuously for at least one year prior to the date on which application for the license is made.”⁶⁸ The Bureau of Motor Vehicles often requires the further submission of physician clearance reports which state that the condition has been under sufficient medical control, that medication has been discontinued for more than one year with no problems, or that the individual and physician believe (and are willing to claim in a sworn statement) that the condition will not affect the individual’s ability to operate a vehicle with adequate safety.⁶⁹ Even after reissuing an unrestricted license, the Bureau of Motor Vehicles registrar reserves the right to revoke or suspend the license if the epileptic condition resurfaces or escapes effective control through medication.⁷⁰

However, the Ohio Revised Code provisions set forth no legal duty upon an individual to disclose a diagnosis or change in medical state of an epileptic condition between licensing periods.⁷¹ Therefore, individuals with epilepsy do not voluntarily disclose their medical conditions between licensing periods, even following an initial diagnosis of epilepsy. If the intent of the Ohio Revised Code provisions is to prevent individuals with epilepsy from driving, the statutes are at least partially ineffective for failing to set forth a disclosure requirement for significant adverse changes in a licensed individual’s epileptic condition that occur between license renewal periods, and for permitting such individuals to retain an unrestricted driver’s license until its ordinary expiration.

⁶⁴ Restrictions Against Issuance of License; Probationary License, or Temporary Instruction Permit; Reinstatement of Suspended License, OHIO REV. CODE § 4507.08(D)(3) (2007).

⁶⁵ *Id.*

⁶⁶ See OHIO REV. CODE § 4507.08 (2007).

⁶⁷ *Id.*

⁶⁸ See Annual License for One with Condition that is Dormant or Under Effective Medical Control, OHIO REV. CODE § 4507.081(C)(2007). This law was enacted on September 1, 1993 pursuant to 1992 S 275, a little less than fifteen years ago. *Id.* This law was originally enacted in 1977 and has not been amended with regard to the medical advances of seizure treatment. See generally Epilepsy Foundation, *Ohio Driving Laws*, *supra* note 60 (survey of Ohio driving laws).

⁶⁹ See OHIO REV. CODE § 4507.08.

⁷⁰ OHIO REV. CODE § 4507.081(D).

⁷¹ See Form and Contents of Application for License; Registration of Voters, OHIO REV. CODE § 4507.06(A)(1)(C) (2007).

V. SEIZURE-RELATED ACCIDENT CASE LAW

Ohio courts impose a negligence standard upon both individuals with epilepsy and the physicians who clear them for driving for foreseeable accidents caused by seizures. In *Krejci v. Akron Pediatric Neurology, Inc.*,⁷² the Court of Appeals of Ohio held that a physician was liable “for negligence in certifying that [a patient’s] condition was medically controlled” due to a special duty to protect other motorists from the potentially dangerous driver.⁷³ Because the physician’s sworn statement is the basis for a patient’s reinstated driving license, the court found that the provision was “intended for the protection of members of the public who may be injured if the applicant’s condition is not medically controlled and he suffers a seizure while driving.”⁷⁴ In determining the physician’s liability, the court differentiated between the physician’s “duty to exercise reasonable care in certifying that the patient’s condition is under effective medical control” and a duty of control, which a physician does not have.⁷⁵ A physician’s duty to third parties exists only in regard to his or her certification of a patient’s ability to drive.⁷⁶ The physician also bears no obligation to report to the state of Ohio those patients who go against medical advice in regard to driving.⁷⁷

In regard to liability of patients with epilepsy, Ohio courts have refused to adopt a doctrine of strict liability.⁷⁸ Therefore, in order for a plaintiff to recover damages resulting from an accident provoked by a defendant’s seizure, the plaintiff must “establish [that the] defendant acted negligently in ignoring an unreasonable and foreseeable risk of harm prior to the onset of sudden unconsciousness.”⁷⁹ Typically, the defendant must have specific knowledge of an impending seizure, rather than a general knowledge of the disorder.”⁸⁰

⁷² *Krejci v. Akron Pediatric Neurology, Inc.*, 511 N.E.2d 129 (Ohio Ct. App. 1987). A physician was sued for wrongful death for his certification of a patient who subsequently suffered an epileptic seizure while driving. *Id.*

⁷³ *Id.* at 131.

⁷⁴ *Id.* at 131

⁷⁵ *Id.* at 131. Unless the patient is committed in an institution or the physician can physically prevent him from driving, physicians have very little control over the patient’s actions. The most the physician can do is strongly recommend not driving and, if the patient poses a significant risk, report the patient – thus breaching patient-physician confidentiality. *Id.*

⁷⁶ *Id.*

⁷⁷ *Id.*

⁷⁸ *Vinci v. Heimbach*, Nos. 73440, 73464, 1998 WL 895381, *4 (Ohio Ct. App. Dec. 17, 1998).

⁷⁹ *Id.*; see also *Goodis v. Finkelstein*, 174 So.2d 600 (1965) (holding that the overhearing of a driver’s statement, “Oh my God, I must have passed out again! I thought this would happen,” was sufficient to show that the driver had forewarning of the risk associated with driving and could be held liable for negligence).

⁸⁰ *Vinci*, 1998 WL 895381.

In determining liability of individuals whose seizures cause accidents, courts evaluate the following elements: “(1) a reasonably foreseeable risk from defendant's operation of his vehicle while he was under medication, (2) a likelihood that defendant would suffer a seizure any greater than that of any member of the general public, or (3) a likelihood that an accident would occur sufficient that a reasonably prudent person would act differently from defendant in the case at bar.”⁸¹ The majority of such negligence cases decided against the individual with epilepsy by showing a failure to heed a physician's warning as to the risk of a recurring seizure while driving, which a reasonably prudent person would heed.⁸² “[C]ontinued driving [without sufficient medical control or clearance], with knowledge of a diagnosed epileptic condition and prior seizures, would provide sufficient evidence of ignoring a foreseeable risk to recover on a claim of negligence if the condition is untreated or the driver ignores his physician's warnings or advice.”⁸³

In defining foreseeability in regard to seizures, Ohio courts take into account many different factors to determine whether the individual had any reason to believe a seizure could occur. In *State v. Boomershine*,⁸⁴ defendant had suffered a seizure approximately three months prior to his accident despite adherence to a medical regimen.⁸⁵ However, defendant had not seen a doctor for ten years and had caused a seizure-related automobile accident approximately nine years earlier.⁸⁶ In addition, defendant had denied his reoccurring seizures on his driver's license application, which the court construed as a tacit admission of knowledge of the risk.⁸⁷ The court found sufficient evidence that defendant's seizures were foreseeable and held defendant liable for negligence.⁸⁸

The existence of a seizure condition is not *de facto* evidence that a seizure is foreseeable. In *Vinci v. Heimbach*,⁸⁹ defendant had suffered two seizures approximately thirty years prior to an automobile accident caused by a third seizure.⁹⁰ He was treated with anti-epileptic medications after his first two seizures and was following the prescriptive regimen proscribed by his treating physician at the time of the accident.⁹¹ The court found for defendant, citing an absence of

⁸¹ *Id.* at *4.

⁸² *Id.*

⁸³ *Id.* at *3. “However, defendant in this case did not ignore the risks from his medical disability and took significant precautions, including all prescribed medicine as directed with regular monitoring.” *Id.*

⁸⁴ *State v. Boomershine*, 619 N.E.2d 52 (Ohio Ct. App. 1993).

⁸⁵ *Id.*

⁸⁶ *Id.*

⁸⁷ *Id.*

⁸⁸ *Id.*

⁸⁹ *Vinci v. Heimbach*, Nos. 73440, 73464, 1998 WL 895381, at *4 (Ohio Ct. App. Dec. 17, 1998). Heimbach suffered an epileptic seizure behind the wheel and struck another vehicle after crossing over the center line. *Id.*

⁹⁰ *Id.* at *1.

⁹¹ *Id.*

evidence in the record that defendant knew or had reason to know that his medicated condition would interfere with his ability to drive.⁹² The court distinguished the case at bar from *Boomershine* in the respect that defendant had no warning as to the onset of his seizure and was “unable to control his mental state.”⁹³ The court further stated that “[h]is unconsciousness was not like that of one who dozes off by voluntarily going to sleep – a condition for which any driver would be responsible.”⁹⁴

VI. PROBLEMS WITH THE APPLICATION

While the ostensible intent of the Ohio Revised Code provisions is to protect public safety, three significant problems exist with the application of the Ohio Revised Code provisions by Ohio courts and agencies: the application of the statutes fail to achieve their basic intent, the application of the laws create unnecessary liability for physicians who, in good-faith, medically clear patients to drive, and the application of the laws constitute an abuse of state’s police power.

A. Basic Intent of the Statutes Has Failed

The Ohio Revised Code provisions are presumably intended to promote public safety by withholding driving licenses from individuals with epilepsy, who are assumed to be of higher risk for accidents while driving.⁹⁵ However, the current provisions fail to fulfill this intent because many individuals continue to drive without disclosing their disorder, because they are not required to do so.⁹⁶ While individuals who withhold information regarding their epileptic condition when procuring or renewing a driving license are subject to criminal violations,⁹⁷ individuals with epilepsy are not required to disclose their epileptic condition when diagnosed, when experimenting with new medications, or upon the occurrence of

⁹² *Id.*

⁹³ *Id.* at *4. “Where the driver of an automobile is suddenly stricken by a period of unconsciousness which he has no reason to anticipate and which renders it impossible for him to control the car he is driving, he is not chargeable with negligence as to such lack of control.” *Id.* at *3, (citing *Lehman v. Hayman*, 164 Ohio St. 595 (1956)).

⁹⁴ *Vinci*, 1998 WL 895381 at *4.

Fainting or momentary loss of consciousness by the driver of an automobile, due to fatigue, is not in itself actionable negligence, and, if a driver stricken by paralysis or seized by an epileptic fit still continues with his hands on the wheel of an automobile which he is driving, and unconscious, so directs it as to cause its collision with another, he cannot be held negligent for the way in which he controls it. The holding is otherwise, if a driver is subject to frequent attacks of vertigo or similar affliction which renders him powerless to control a moving machine and, with full knowledge of such affliction, and its effect, intentionally runs a machine at a speed dangerous to other travelers and persons on the highway. *Weldon Tool Co. v. Kelley*, 76 N.E.2d 629, 631 (Ohio Ct. App. 1947) (citing 1 *Blashfield Encyclopedia of Automobile Law & Practice* 656).

⁹⁵ *Salinsky*, *supra* note 8, at 471.

⁹⁶ OHIO REV. CODE § 4507.06(A)(1)(C) (2007). When applying for a driver’s license issuance or renewal in Ohio, an individual must comply with the requirement of disclosure under oath as to “whether the applicant is now or ever has been afflicted with epilepsy.” *Id.*

⁹⁷ OHIO REV. CODE § 2921.23.

additional seizures.⁹⁸ Individuals are strongly advised by physicians to abstain from driving; however there is no legal requirement for these individuals to restrict their driving.⁹⁹ Thus, individuals simply have a moral obligation to either voluntarily disclose their condition to the state or abstain from driving.¹⁰⁰

In an attempt to prevent these types of loopholes, several jurisdictions have imposed on physicians a compulsory disclosing standard regarding individuals with epilepsy.¹⁰¹ The support for mandatory reporting is based on concerns for public safety in view of a majority of individuals who do not notify the licensing authority of their newly diagnosed or recurring epileptic condition, except during normal license renewals.¹⁰² Compelling physicians to disclose epileptic conditions to the state licensing authorities might reduce the incidence of individuals who do not disclose information for fear of losing their driver's license. However, studies have shown that compulsory reporting does not protect the individual with epilepsy or the general public.¹⁰³ Jurisdictions with compulsory physician reporting standards had a similar accident rate as compared with those having no compulsory physician reporting standards.¹⁰⁴ Additionally, the enforcement of a compulsory physician reporting statute encourages patients to withhold information about their seizures out of fear that the physician will report the condition to licensing authorities.¹⁰⁵ This scenario results in individuals not only avoiding the medical attention they need, but continuing to drive despite medical advice, thereby increasing the population risk of seizure-induced accidents.¹⁰⁶

While the legislature is not required to enact exact laws when addressing a new social issue, it is expected that any loopholes or discriminatory effects of the laws will be promptly evaluated and resolved. The current Ohio Revised Code provisions protect, to a limited extent, the public interest by preventing some individuals with epilepsy from driving; however, it does so at a significant expense of individual autonomy.¹⁰⁷ These laws have existed unchanged despite discrimination and medical

⁹⁸ See OHIO REV. CODE § 4507.06(A)(1)(C).

⁹⁹ See generally EpilepsyFoundation.org, Driving & Epilepsy: Physician Issues - Physician Immunity Laws, <http://epilepsyfoundation.org/about/professionals/medical/drivingphys.cfm> (last visited Feb. 10, 2008) [hereinafter Epilepsy Foundation, *Physician Issues*]. However, not heeding a physician's medical advice in regard to driving is strong evidence for a case of negligence. *Vinci*, 1998 WL 895381 at *3.

¹⁰⁰ Epilepsy Foundation, *Physician Issues*, *supra* note 99.

¹⁰¹ *Id.* California, Delaware, Nevada, New Jersey, Oregon, and Pennsylvania are the only states that have expressly mandated physician disclosure laws. *Id.*

¹⁰² Richard S. McLachlan et. al., *Impact of Mandatory Physician Reporting on Accident Risk in Epilepsy*, 48 EPILEPSIA 1500, 1500 (2007).

¹⁰³ *Id.* at 1502.

¹⁰⁴ *Id.*

¹⁰⁵ *Id.* at 1500-03.

¹⁰⁶ *Id.*

¹⁰⁷ Vogtle, *supra* note 12, at 55.

advancements in treatment of the disorder.¹⁰⁸ A fresh analysis and restructuring of the statute and its various applications are respectfully suggested.

B. Unnecessary Imposition of Negligence upon Clearing Physicians

Pursuant to Ohio Revised Code provisions, physicians may certify a patient's medical condition to the state licensing authorities.¹⁰⁹ While the determination of whether or not to reinstate the license is at the discretion of the state, physician reports are the basis of the state's decision.¹¹⁰ Therefore, physicians have much discretion in determining when to medically clear an individual to drive¹¹¹ because Ohio has not set a specific seizure-free time requirement for the reinstatement of a license.¹¹²

However, physicians who medically clear patients for driving may be held liable for injuries resulting from seizure-related accidents caused by patients.¹¹³ Physicians have no explicit immunity for the medical clearance reports that they may file with

¹⁰⁸ See generally Epilepsy Foundation, *Ohio Driving Laws*, *supra* note 60 (survey of Ohio driving laws).

¹⁰⁹ OHIO REV. CODE § 4507.08(D)(3); OHIO REV. CODE § 4507.081(C).

¹¹⁰ *Krejci*, 511 N.E.2d at 131.

Ohio's statutory scheme requires the Registrar of Motor Vehicles to issue a license to one subject to epileptic seizures if a physician certifies that the individual's condition is under effective medical control. R.C. 4507.08(B) reads in pertinent part:

"... A restricted license effective for six months *shall* be issued to any person who is otherwise qualified who is subject to any condition which causes episodic impairment of consciousness or a loss of muscular control if the person presents a statement from a licensed physician that his condition is under effective medical control and the period of time for which the control has been continuously maintained. ..."

Thus, it is clear that the physician's statement is the basis for the registrar's issuance of a license to the applicant, thereby authorizing him to drive on public roads. The provision then is one intended for the protection of members of the public who may be injured if the applicant's condition is not medically controlled and he suffers a seizure while driving. Therefore, in undertaking to provide such statement for the registrar, the physician has a duty to determine within reasonable medical certainty that the patient's condition is in fact under effective medical control.

Id.

¹¹¹ June M. Sullivan, *Physicians as Gatekeepers For Society: Confidentiality of Protected Health Information Versus Duty to Disclose At-Risk Drivers*, 16 NO. 1 HEALTH LAW 20, 20 (2003).

Physicians play a key role in identifying and assessing the impact that physical and mental conditions have on driving impairment. Their unique position as gatekeepers places legal and ethical duties on physicians to guard the public's safety. Physicians have a simultaneous duty to guard patients' confidentiality in protected health information, especially in light of the recent Health Insurance Portability and Accountability Act of 1996.

Id.

¹¹² *Ohio Driving Laws*, *supra* note 60.

¹¹³ See *Krejci*, 511 N.E.2d 129.

the state.¹¹⁴ In certifying that a patient's epilepsy is under sufficient medical control, a physician bears an affirmative duty to third party motorists to "exercise reasonable medical care in certifying that the patient's condition is 'under effective medical care'."¹¹⁵ Thus, the physician has an affirmative duty to determine that the patient is under sufficient medical control or that it is unforeseeable that the patient will experience another seizure while driving.¹¹⁶

While intended to be objective, "reasonable medical care" is an inconsistent standard. Physicians are inconsistent in determining when an individual is medically controlled and does not pose a significant risk of harm while driving.¹¹⁷ Non-neurologists, such as family practitioners and general physicians, have more restrictive beliefs than legally necessary for individuals with epilepsy.¹¹⁸ Family physicians are more likely than neurologists and specialists to support stringent driving restrictions, mandatory physician reporting and set seizure-free driving periods for individuals with epilepsy.¹¹⁹ Such a discrepancy adds to the inconsistency of licensing restrictions and may lead to significant differences in medical clearance.¹²⁰

Because the licensing authorities rely upon physician's reports when reinstating a license, a physician is not only making a medical decision, but a decision based primarily on risk when medically clearing an individual to drive.¹²¹ This is a legal determination that the physician is neither trained nor authorized to make, and for which the physician may be held personally liable in the event of subsequent harm

¹¹⁴ *Id.*; see also Epilepsy Foundation, *Ohio Driving Laws*, *supra* note 60.

¹¹⁵ *Krejci*, 511 N.E.2d at 130; see also OHIO REV. CODE § 4507.08(B); see also Andrew B. Black, *Confidentiality and Driver Licensing Authorities*, 22(2) MED. & L. 333 (2003).

A doctor's duty of care for a patient involves many responsibilities including thoroughness, competence, knowledge, the provisions of information and advice, the opportunity for choice and the maintenance of confidentiality. A doctor also has a duty of care to the broader community. ... A difficulty will arise therefore when a doctor's duty of care for others in the community may be performed only by diminishing or undermining that for the patient.

Id. at 333.

¹¹⁶ *Krejci*, 511 N.E.2d at 131.

¹¹⁷ Vogtle, *supra* note 12 at 60.

There was some disagreement as to what constitutes controlled seizures. Seventy-five percent of respondents indicated no monthly seizures meant seizure control, with 25% of the study sample indicating they defined one or more seizures a month as seizure control. This leaves open to question these physicians' definitions of uncontrolled seizure disorder, which, in turn, has ramifications regarding how their patients are educated about driving restrictions.

Id.

¹¹⁸ Vogtle, *supra* note 12 at 55.

¹¹⁹ *Id.*

¹²⁰ *Id.*; see also Epilepsy.com, *Physician Reporting of Patients When Seizures May Affect Driving*, http://professionals.epilepsy.com/page/hallway_driving.html (last visited Feb. 10, 2008) [hereinafter Epilepsy.com, *Hallway*].

¹²¹ See *Krejci*, 511 N.E.2d at 131; see also Sullivan *supra* note 111.

caused by cleared drivers.¹²² This legal determination may be a contributing factor to the discrepancy in medical clearance.

The perceived risk of liability for providing a medical release that precedes a seizure-related accident may result in physicians conservatively withholding medical certification to an unduly conservative extent.¹²³ This apprehension to endorse the medical certification results in the individual being precluded from driving for a longer period than medically or legally necessary.¹²⁴ The protracted restriction of rights is contrary to public policy because the deprivation of rights of the individual past the point of medical necessity is no longer balanced or justified by a sufficiently achievable state interest in roadway safety.¹²⁵

C. Abuse of Police Power

While driving is a privilege and not a legal right, the state may only restrict individuals from driving on the basis of a significant state interest at issue,¹²⁶ and the state must adhere to all constitutionally protected classes and rights. The Ohio Revised Code restrictions on individual drivers with epilepsy are an abuse of the police power because the provisions are both over- and under-inclusive, and create an undue burden upon the individual with epilepsy which does not sufficiently protect the ostensible state interest.

1. Over-Inclusive

The Ohio Revised Code provisions are substantially over-inclusive because the statutes do not consider the severity of seizures when revoking an individual's

¹²² See *Krejci*, 511 N.E.2d 129.

¹²³ See *Schmidt v. Mahoney*, 659 N.W.2d 552, 555 (Iowa 2003) (holding that "[i]n order to curtail liability, physicians may become prone to make overly restrictive recommendations concerning the activities of their patients and will exercise their role as reporters to the department of transportation in an inflexible manner not in their patient's best interest").

A number of considerations relevant to the duty analysis strongly militate against imposition of duty here.... Concern about how a course of treatment might affect third parties could easily influence the way in which therapists treat their patients. Under a rule imposing a duty of care to third parties therapists would feel compelled to consider the possible effects of treatment choices on third parties and would have an incentive to compromise their treatment because of the threatened liability. This would be fundamentally inconsistent with the therapist's obligation to the patient.... Hoping to avoid liability to third parties, ... a therapist might instead find it necessary to deviate from the treatment the therapist would normally provide, to the patient's ultimate detriment. This would exact an intolerable high price from the patient-therapist relationship and would be destructive of that relationship. *J.A.H. v. Wadle & Associates, P.C.*, 589 N.W.2d 256, 262-63 (Iowa 1999).

¹²⁴ *Id.* On the contrary, physicians who want to change medication of individuals who are medically controlled and have been seizure free may be less likely to change medications due to the risk of loss of a driver's license for a period of time if a breakthrough seizure were to occur. See Stephen Brown & Johnathan Bird, *Continuing Professional Development: Medico-Legal Aspects of Epilepsy*, 10 *SEIZURE* 68 (2001).

¹²⁵ See generally Brown & Bird, *supra* note 124, at 69.

¹²⁶ See *State v. Tanner*, 472 N.E.2d 689, 693.

driving privileges. Not all types of epilepsy are severe enough to warrant driving restrictions.¹²⁷ Petit mal seizures often only consist of staring spells which may last mere seconds and partial seizures only cause sudden jerking and no loss of consciousness.¹²⁸ These individuals may be unaware of their condition, because the effects of the seizures are so mild.¹²⁹ Thus, these seizures may not negatively affect their driving, making their inclusion within the statutes inappropriate.¹³⁰

Similarly, the Ohio Revised Code provisions do not consider the frequency of seizures when revoking an individual's driving privileges. Individuals with epilepsy are restricted from driving whether they experience seizures every day or have experienced two seizures in their lifetime and have been seizure-free for two years.¹³¹ Despite the varying frequency of seizures, each individual must receive clearance from a physician in order to procure and maintain a long-term license. The only differentiation by the statutes based on the severity of an epileptic condition is ancillary; seizure frequency is likely negatively correlated to the likelihood of a physician giving that individual medical clearance to drive.

Not all individuals with epilepsy are high-risk while driving, despite the image of being dangerous both to themselves and to others.¹³² Approximately eighty percent of patients with epilepsy did not have attacks while driving,¹³³ and females with epilepsy have a lower rate of accidents than males without epilepsy.¹³⁴ While an average driver has a ten percent risk of causing an accident, a quarter of a percent of all accidents are caused by seizures.¹³⁵ It has been estimated that the average driver has a chance of being involved in an accident with someone having a seizure once in every four thousand years.¹³⁶ There is little statistic evidence to support restrictions on individuals with epilepsy in comparison to other "normal" drivers or medical conditions.

¹²⁷ Epilepsy Foundation, *Causes*, *supra* note 13. See generally Ormond, 8 N.C. App 662; Miller, 89 Pa.D & C 486.

¹²⁸ Epilepsy Foundation, *Causes*, *supra* note 13.

¹²⁹ *Id.*

¹³⁰ *Id.* For instance, some seizures do not impair consciousness, occur only nocturnally, or have significant early warning signs that allow the individual to avoid driving when a seizure is more likely to occur. See generally eMedTV, *Seizures & Driving*, <http://nervous-system.emedtv.com/seizures/seizures-and-driving.html> (last visited Feb. 10, 2008).

¹³¹ See generally OHIO REV. CODE §§ 4507.06(A)(1)(C), 4507.08(B), (D)(3), 4507.081(C).

¹³² M. Beaussart-Defaye, *Epileptic Drivers – A Study of 1,089 Patients*, 16 MED. & L. 295, 295 (1997).

¹³³ *Id.* at 298.

¹³⁴ McLachlan, *supra* note 102, at 1503.

¹³⁵ Elinor Ben-Menachem, *Toward a More Pragmatic View of Driving and Epilepsy*, 4(4) EPILEPSY CURRENTS 133, 133-4 (2004).

¹³⁶ *Id.*

2. Under-Inclusive

When procuring or renewing a driver's license, the Bureau of Motor Vehicles must determine whether the individual has a "physical or mental condition which may impair the ability of the applicant to operate a motor vehicle safely."¹³⁷ While not expressly defined, courts have found that afflictions such as heart attack, cardiovascular disease, fatigue, stroke, insulin-treated diabetes, vertigo, dementia, and migraines each have a high likelihood of lapses of consciousness or impairment and may substantially impair a driver's ability to operate a motor vehicle.¹³⁸ Studies have suggested that while epilepsy has a 1.95 times greater risk of causing an accident than the control group, cardiovascular disease has a 1.62 times greater risk, mental illness a 2.12, and diabetes a 1.78.¹³⁹

However, the standard licensing authority investigation of the applicant's medical condition inquires "whether the applicant is now or ever has been afflicted with epilepsy, or whether the applicant now is suffering from any physical or mental disability or disease."¹⁴⁰ This inquiry colors the type of medical condition that the applicant is apt to disclose by implying that the registrar is inquiring about medical conditions related to or similar to epilepsy.¹⁴¹ As a result of this inquiry, epileptic

¹³⁷ OHIO ADMIN. CODE § 4501:1-1-18 (2007).

The registrar of motor vehicles shall include as part of the application for the original operator's license, or a renewal thereof, questions as to the existence of a physical or mental condition which may impair the ability of the applicant to operate a motor vehicle safely. Such questions shall be answered under oath by the applicant. If the answer to any such question indicates the existence of any such physical or mental condition, the registrar in his discretion may require an examination of the applicant by a licensed physician as a prerequisite to the issuance of an operator's license. Any expense occasioned by such examination shall be borne by the applicant.

.... When in the course of a routine driver license examination the driver license examiner has reason to believe that the applicant has a physical or mental condition which may impair the ability of the applicant to operate a motor vehicle safely, the applicant shall be instructed by the bureau of motor vehicles to obtain a signed medical report from a licensed physician. The medical report shall be returned to the bureau within twenty days of the date of such physical or mental examination for evaluation by the bureau. No license shall be issued to such applicant prior to a favorable evaluation of the medical report by the bureau or driver examination station.

Id.

¹³⁸ Danne, *supra* note 62.

¹³⁹ Devereux, *supra* note 7, at 126-7.

¹⁴⁰ OHIO REV. CODE § 4507.06(A)(1)(C).

¹⁴¹ See Ohio Admin. Code § 4501:1-1-18. Typically, specific afflictions that are subject to automatic licensing restrictions are not listed within the statute, but a general question as to whether the applicant can operate a vehicle safely in spite of his medical condition is included. Danne, *supra* note 62. While individuals are required to disclose all medical conditions that may impair driving, the general public may not consider migraines or diabetes to be comparable to epilepsy, which is expressly stated within the inquiry. The phrase "physical or mental disability or disease" is not likely to result in the answer of diabetes, whereas a question of medical conditions that gives some explicit examples may. By specifically targeting epilepsy and not giving other examples of conditions that may substantially impair an individual's ability to drive (such as heart disease), applicants are probably less likely to

conditions are more likely to result in a suspension of driving privileges than other medical conditions, despite the comparable risk created by other medical conditions.¹⁴² This disparate impact could be the result of the ambiguity of the inquiry into the applicant's medical conditions, which is colored by the inclusion of epilepsy. As a result of this ambiguity, the law is in need of reevaluation.

3. Undue Burden

In addition to being both over- and under- inclusive, the application of the Ohio Revised Code provisions create an undue burden on individuals with epilepsy. "Car driving today is essential to be socially and professionally integrated. Thus, forbidding a patient to drive is heavily penalizing."¹⁴³ Driving restrictions can effectively serve "as a barrier to employment, socialization or to taking care of needs of daily living such as grocery shopping."¹⁴⁴ Individuals who are not given medical clearance to drive, even temporarily, may find it difficult to find or maintain employment without suitable public transportation or the ability to carpool.¹⁴⁵ While a medical authorization can allow for future driving, some individuals may not receive medical clearance during the adjustment of a medical regimen.¹⁴⁶ This delay

disclose these types of medical conditions. However, these more "normal" medical conditions can also substantially impair an individual's ability to operate a vehicle. *See generally* American Medical Association Physician's Guide to Assessing and Counseling Older Drivers, Chapter 9, Medical Conditions and Medications That May Impair Driving, accessed August 15, 2003, *available at* <http://www.ama-assn.org/ama1/pub/upload/mm/433/chapter9.pdf>.

¹⁴² *See* McLachlan, *supra* note 7.

¹⁴³ Beaussart-Defaye, *supra* note 132.

¹⁴⁴ Lee Ann Kingham, *Driving and Epilepsy: Changing the Law in Maryland*, 35(3) *EPILEPSIA* 693, 693 (1994).

¹⁴⁵ Epilepsy.com, *Employment*, *supra* note 51.

¹⁴⁶ This is, of course, assuming the individual can afford the medication to begin with. *See generally* American Family Physician, *Epilepsy, Driving, and the Law*, <http://www.aafp.org/afp/990101ap/curbside.html> (last visited Feb. 10, 2008) [hereinafter *Epilepsy, Driving, and the Law, Curbside*]. Some individuals who lack health insurance cannot afford the expensive anti-seizure medication. In one situation, a woman with a seizure disorder had stopped taking her medication due to lack of health benefits at her job. She was unable to seek help through public health agencies in affording the medication. As a result, she continued to drive and had a one-car seizure-related accident. It was not until she got a job with health benefits that she began to take her medication. This is clearly at odds with public policy. Not only is this woman not seeking the medical attention she needs, but she cannot even afford the medication, or alternative transportation means. *Id.*

In an attempt to contain costs, Medicaid, Medicare and private insurance companies use drug formularies to assess the amount they will reimburse patients covered under their plans. The formulary drugs are supposedly selected by the health plan based on safety, efficacy and cost. When patients use formulary drugs, they pay less for their medications. But this system does not always guarantee the best treatment. "The older medications are the cheapest, so these are the ones that tend to be covered under formularies," Hargis explained. "It is a dollars and cents issue. But if a patient has one seizure because of being on the wrong medication, it can cost thousands of dollars in terms of emergency room visits, loss of job or injury."

Epilepsy USA, *Excludes Newer Drugs*, *supra* note 21 at ¶ 3. "The guidelines also give new urgency to the need to expand coverage of all epilepsy medications. ... Treatment decisions

can have a negative affect on a patient's current employment or educational situation because of difficulties in finding suitable transportation.

Many individuals who experience seizures may be inclined to avoid seeking medical treatment or withhold information from their physicians in order to maintain their driver's license.¹⁴⁷ Factors such as the availability of public transportation, employment, education, and social life may influence an individual not to seek medical treatment for fear of losing their ability to drive.¹⁴⁸ This outcome does not fulfill the legislative intent of public safety because a group of patients are not only driving without sufficient medical control, but also are not seeking necessary medical attention for their conditions.¹⁴⁹

Therefore, individuals with epilepsy face a discretionary dilemma: whether to follow legal and medical advice and to abstain from driving, or whether to maintain their individual autonomy by continuing to drive. Some studies have found that nearly twenty percent of individuals who experienced one seizure a year and twenty four percent of those who experienced daily seizures continue to drive.¹⁵⁰ Fifty one percent of individuals who were employed continued to drive as compared to twenty percent of those who were unemployed.¹⁵¹ In cities where public transportation is not readily available, or for individuals whose jobs are dependent upon their ability to drive, this law is especially punitive.

It is within the state's police power to make reasonable, necessary and appropriate provisions to promote the health and safety of the community.¹⁵² However, "[t]he means adopted must be suitable to the end in view, must be impartial in operation and not unduly oppressive upon individuals, must have a real and substantial relation to their purpose, and must not interfere with private rights beyond the necessities of the situation."¹⁵³ If the intent of the statutes is to protect the public from foreseeable accidents caused by lapses of consciousness, the state has abused its police power in restricting individuals with epilepsy. The means adopted are not suitable to the end in view because of the over- and under-inclusive nature of the law.¹⁵⁴ Also, the law is "unduly oppressive upon individuals" and "interferes

for epilepsy need to be made by informed physicians in partnership with their patients and not by Congress, HMOs (health maintenance organizations) or insurance companies." *Id.* at ¶ 10. See generally Epilepsy.com, Community Forum, <http://www.epilepsy.com/forum/129> (last visited Feb. 10, 2008).

¹⁴⁷ McLachlan, *supra* note 102, at 1503.

¹⁴⁸ *Id.*; see also Epilepsy, Driving, and the Law, *Curbside*, *supra* note 146.

¹⁴⁹ McLachlan, *supra* note 102, at 1503. Economic factors, such as employment, independently determine whether an individual with epilepsy would drive. Ramon Edmundo D. Bautista & Peter Wludyka, *Driving prevalence and factors associated with driving among patients with epilepsy*, 9 EPILEPSY & BEHAVIOR 625, 628 (2006).

¹⁵⁰ Bautista & Wludyka, *supra* note 149, at 627.

¹⁵¹ *Id.* at 628.

¹⁵² See *State v. Tanner*, 472 N.E.2d 689 (Ohio 1984). See also *Froelich v. City of Cleveland*, 124 N.E. 212 (Ohio 1919).

¹⁵³ *Froelich* 124 N.E. at 212.

¹⁵⁴ *Id.*; see generally Epilepsy Foundation, *Causes*, *supra* note 13; Beaussart-Defaye *supra* note 132; Ben-Menachem *supra* note 135; Devereux *supra* note 7.

with private rights beyond the necessities of the situation” because it deprives individuals of their legal privilege to drive, which collaterally takes away opportunities for employment, education and other important aspects of personal autonomy.¹⁵⁵ Therefore, the state has abused its police power by protecting public safety by only restricting licensing of individuals with epilepsy.

VII. CHANGES IN APPLICATION

A reevaluation and adaptation of the application of the Ohio Revised Code provisions pertaining to driving privileges of individuals with epilepsy may achieve both a greater respect for the individual autonomy of such individuals and a better productivity of public welfare.¹⁵⁶ Several adaptations to the application of the current Ohio Revised Code may be considered in pursuit of this goal: a three-month mandated suspension of driving privileges, physician immunity for good-faith certifications, a negligence standard for drivers with epilepsy, a more subjective approach to evaluating whether an individual should be restricted from driving, and governmental aid.

A. *Three-Month Mandated Suspension of Driving Privileges*

The Bureau of Motor Vehicles should establish a policy mandating a three-month suspension of driving for individuals who have just experienced a seizure.¹⁵⁷ After the three-month period, reinstatement of driving privileges may be left to the discretion of the individual’s physician and based upon the individual’s medical record. This approach simultaneously closes the loophole that currently legalizes driving between the diagnosis of an epileptic condition and the renewal of a driving license, more selectively applies the driving restriction to the circumstances of the individual, and encourages individuals to adhere to driving restrictions.¹⁵⁸

¹⁵⁵ *Froelich* 124 N.E. at 216. See *supra* note 51. In effect, this law is burdensome to the individual by severely limiting their ability to function in their daily activities, including both their employment and social lives. See generally BBC News, *Plea to Ease Epilepsy Driving Ban*, news.bbc.co.uk, Jul. 20, 2003, <http://news.bbc.co.uk/1/hi/health/3078609.stm>.

¹⁵⁶ See Kingham, *supra* note 144.

There are three steps in changing U.S. state laws or regulations regarding driving and epilepsy: (a) identifying the issue as a priority and determination of the recommended change, (b) establishing the legislative strategy necessary to accomplish this change, and (c) planning and executing the steps necessary for successful implementation of the change.

Id. at 693.

¹⁵⁷ See generally American Academy of Neurology, Position Statement on Physician Reporting of Medical Conditions That May Affect Driving Competence, September 2006, available at <http://www.aan.com/globals/axon/assets/2324.pdf> [hereinafter AAN, *Position Statement*]. “The probability that seizures will not repeat in one year, if there is a seizure-free period of 3 months, is 85%.” Joze Groselj, *Epilepsy and Driving License Regulations in Slovenia*, 16 MED. & L. 289, 292 (1997). “Although the three-month standard continues to be supported by a majority of AAN members, the Academy supports continued research and surveillance to determine whether a three-month seizure-free interval is the best marker for reasonable driving safety for people with epilepsy.” AAN, *Position Statement*, *supra*, at FN 5.

¹⁵⁸ See generally Allan Krumholz, To Drive or Not to Drive: The 3-Month Seizure-Free Interval for People With Epilepsy, 78 MAYO CLIN PROC. 819 (2003) (citing A.E. Sonnen,

While shortening the mandatory restriction period for individuals with epilepsy might be presumed to increase the incidence of seizure-related accidents, studies have shown no significant increase in such accidents.¹⁵⁹ In Arizona, the legislature reduced the period of epilepsy-based driving license restrictions from twelve seizure-free months to three.¹⁶⁰ When the increase in population, number of motor vehicles, and time spent on the road were statistically normalized, the number of seizure-related accidents did not increase, nor did the number of fatalities resulting from those types of accidents.¹⁶¹ Thus, the protracted seizure-free period required before reinstating driving privileges following a seizure was ineffective for promoting public safety.

B. Physician Immunity for Good-Faith Certifications

With regard to physician liability in certifying individuals with a controlled epileptic condition to drive, physicians should be exempted from liability for good-faith certifications of driving safety for patients who later experience a seizure-induced automobile accident.¹⁶² A state policy may be developed to assist physicians in providing accurate and well-founded certifications with a reduced fear of lawsuit.¹⁶³ The state policy may specify a particular period of time wherein physicians may evaluate the patient's progress while not being too restrictive upon drivers who have experienced a breakthrough seizure. With respect to individuals who have abided by the mandatory suspension, a physician may make a decision based solely on an individual's medical record, rather than based on the perceived liability that will result if their medical diagnosis varies from the likely recommendations of other physicians.¹⁶⁴

The Bureau of Motor Vehicles may additionally promulgate guidelines according to which physicians may gauge the risk of an individual while driving.¹⁶⁵ Such guidelines may provide a standard for this determination, and may therefore decrease the disparity of clearance among different types of physicians.¹⁶⁶ Moreover, these guidelines may be formulated in cooperation with the American Academy of

Epilepsy and Driving: A European View. Paswerk Bedrijven, Haarlem: International Bureau for Epilepsy; 1997:11-32). "A recognized problem of a relatively longer seizure-free interval is that it discourages people with epilepsy from complying with driving rules, whereas shorter seizure-free intervals appear to encourage such compliance." *Id.* at 817.

¹⁵⁹ See Joseph F. Drazkowski, Robert S. Fisher, and David. E. Blum, *Driving Crashes in Arizona After Reducing the Required Seizure-Free Interval*, 40(7) EPILEPSIA 104 (1999).

¹⁶⁰ *Id.*

¹⁶¹ *Id.*

¹⁶² AAN, *Position Statement*, *supra* note 157. "Physicians should enjoy immunity for choosing to report or not report, so long as the decision is made in good faith." *Id.* at ¶ 5.

¹⁶³ *Id.*

¹⁶⁴ See Vogtle, *supra* note 12; see also Epilepsy.com, *Hallway*, *supra* note 120.

¹⁶⁵ See generally Groselj, *supra* note 157 see also AAN, *Position Statement*, *supra* note 157. Three months is the medically supported amount of time for a restriction. Six months is arbitrary.

¹⁶⁶ See Vogtle, *supra* note 12, at 60.

Neurology and the American Epilepsy Society, which are well-positioned to generate such documents because of their familiarity with the disorder and its prognosis.¹⁶⁷ This guidance may facilitate physicians in treating the disorder, decrease perceived liability, and increase a patient's individual autonomy.

C. Negligence Standard for Drivers with Epilepsy

Regarding liability for seizure-related accidents, individuals who have been medically cleared to drive should be held to a negligence standard for similar medical conditions.¹⁶⁸ In situations "[w]here the driver of an automobile is suddenly stricken by a period of unconsciousness which he has no reason to anticipate and which renders it impossible for him to control the car he is driving, he is not chargeable with negligence as to such lack of control."¹⁶⁹ In these cases, the defendant holds the burden of proof that he had no reason to believe that such a lapse of consciousness would occur.¹⁷⁰ This steep burden protects the public interest in road safety, while allowing those individuals who have outgrown their seizure disorder or have not experienced seizures for a significant period of time to be absolved of liability.

Several factors may be evaluated when determining whether an individual's medical condition could adversely affect the ability to operate a motor vehicle safely.¹⁷¹ Some courts have considered the individual's previous driving proficiencies, the prognosis or severity of the medical condition, the individual's medical history, the frequency of periods of unconsciousness or lack of control, and the ability of the individual to anticipate such periods.¹⁷²

¹⁶⁷ Epilepsy USA, *Excludes Newer Drugs*, *supra* note 21. See also American Academy of Neurology, Physician Reporting of Medical Conditions that may Affect Driving Competence (2006) available at <http://www.aan.com/advocacy/issues/tools/56.pdf> [hereinafter AAN, *Physician Reporting*].

¹⁶⁸ Compare *Beasley v. Amburgy*, 70 S.W.3d 74 (Tenn. Ct. App. 2001) (holding that a driver's sudden loss of consciousness was not foreseeable and that a 20 hour lapse from medication was not sufficient); *Watts v. Smith*, 226 A.2d 160 (D.C. 1967) (holding that a driver's awareness of high blood pressure requiring pills that result in dizzy spells was sufficient knowledge to find defendant liable for negligence in connection with automobile accident); *Porter v. Price*, 355 P.2d 66 (Utah 1960) (holding that a well-medicated diabetic was not liable for negligence as a result of a diabetic blackout); *Keller v. Wonn*, 87 S.E.2d 453 (W. Va. 1955) (holding that the driver's heart attack was not foreseeable because he was not informed of the potential dangers associated with the condition and driving); *Schneider v. Van Wyckhouse*, 54 N.Y.S.2d 446 (1945) (holding that a driver with heart disease was liable for negligence after having a heart attack behind the wheel).

¹⁶⁹ *Roman v. Estate of Gobbo*, 99 Ohio St.3d 260, 261 (2003).

¹⁷⁰ *Id.*

¹⁷¹ *Danne*, *supra* note 62.

¹⁷² *Id.* A history of no or few traffic accidents is a practical indicator of that individual's ability to safely operate a vehicle, in spite of his medical condition. *Id.* Similarly, a significant medical history of lapses of consciousness indicates a susceptibility to future attacks and is dispositive of an individual's inability to safely operate a vehicle. *Id.*

A dormant history of seizures does not make a future seizure foreseeable.¹⁷³ “[A] driver who operates a vehicle with knowledge of any medical condition should [not] bear the risk of injuries that result from loss of consciousness or incapacitation due to the condition.”¹⁷⁴ Such a definition of foreseeability would “remove any consideration of the reasonableness of choosing to drive despite imperfect health and would essentially mean that all drivers with any history of illness are unable as a matter of law to prevail on a sudden-medical-emergency defense.”¹⁷⁵ Essentially, that type of foreseeability would not absolve anyone who has ever suffered a lapse of consciousness from liability.

In view of this definition of foreseeability, the negligence standard for other medical conditions is sufficient for individuals who have experienced seizures. This standard absolves liability for those who experience unforeseeable seizures while holding those who experience foreseeable seizures liable for seizure-related accidents. Like other medical conditions, a “driver who suddenly and quite unexpectedly suffers a heart attack does not become negligent when he loses control of his car and drives it in a manner which would otherwise be unreasonable; but one who knows that he is subject to such attacks may be negligent in driving at all.”¹⁷⁶

D. Subjective Approach

A more case-specific approach may be developed to mandate an appropriate driving restriction for an individual with epilepsy.¹⁷⁷ Neither the current state of Ohio formulation of the driving restriction, nor harsher legal restrictions on individuals attempted in other states, have been successful in significantly reducing seizure-related accidents.¹⁷⁸ By mandating a three-month suspension from driving upon the occurrence of a seizure, the Bureau of Motor Vehicles may encourage physicians to advise such individuals to take a short hiatus from driving, followed by an additional assessment of the individual’s apparent condition after three months. This revised process places a significant amount of discretion upon the physician, while still restricting individuals with epilepsy from driving during the high-risk period wherein a subsequent seizure is more likely.¹⁷⁹ After three months, a physician may be better informed as to whether the individual should still be precluded from driving or can safely drive a motor vehicle without being high risk for causing an accident.

E. Governmental Aid

If an individual is prevented from driving due to a mandatory restriction or voluntary avoidance of a perceived risk of uncontrollable seizures, governmental aid

¹⁷³ *Id.*

¹⁷⁴ *Id.*

¹⁷⁵ *Id.*

¹⁷⁶ *Id.* (citing See 2 Restatement of the Law 2d, Torts (1965) 18, Section 283C, Comment c).

¹⁷⁷ *Supra* note 26 at 673.

¹⁷⁸ *Id.*

¹⁷⁹ Groselj, *supra* note 157; *see also* AAN, *Position Statement*, *supra* note 157.

may be provided to help the individual cope with the restriction on driving privileges.¹⁸⁰ Such aid includes subsidization of public transportation costs, such as a bus pass, or the provision of transportation to such individuals through a public agency. To accommodate transportation difficulties, such agencies could communicate with employers to coordinate car pooling, personally transport individuals, or elicit help from private transportation companies or public officials to help transport these individuals. In addition to ameliorating difficulties related to daily activities and employment, such governmental action and support may encourage individuals to comply with a prescribed anti-seizure medication regimen in order to expedite the renewal of a valid license. Additionally, because these individuals have an affordable means of running errands and getting to work, their likelihood of driving against medical advice or without a license may be reduced.

VIII. CONCLUSION

“[It is] about fighting for people’s rights. People with epilepsy look normal because they are.”¹⁸¹ As discussed above, individuals with epilepsy face severe social disabilities and stigma as a result of the epilepsy diagnosis, are less successful in both employment and school, and often suffer from psychological difficulties, such as depression.¹⁸² In addition, the inability to drive simply exaggerates their diminished autonomy.¹⁸³ “The ability to drive in the United States is important for personal autonomy, which is a basic premise of American life. Persons who have recurrent seizures lose this autonomy, and as a result, their lives are significantly limited by . . . difficulties with employment, social isolation, and dependence on others.”¹⁸⁴ Absent a sufficient showing that these individuals are particularly dangerous while driving, care should be taken when restricting their driving privileges so as not to exacerbate their existing limitations and diminished autonomy.¹⁸⁵

Despite implied good-faith legislative intent to protect pedestrians and other drivers from seizure-related accidents, available medical evidence does not support the notion that individuals with epilepsy present a higher driving risk than other individuals who are permitted to drive. “Although the number of accidents at the wheel is not negligible, the number of accidents caused by seizures remains low and

¹⁸⁰ AAN, *Physician Reporting* *supra* note 167.

¹⁸¹ University of Southern California, *Epilepsy Patients Seek Answers, Understanding*, ANNENBURG FILES, http://annenbergfiles.org/2007/11/epilepsy_patients_seek_answers.html.

¹⁸² *See supra* note 51.

¹⁸³ *See Fisher, supra* note 37.

Limitations on lifestyle was second to fear as a category of important subjective disability in epilepsy. The largest single lifestyle limit was being unable to drive, listed by 10.9% of our survey population as the ‘worst thing’ about having epilepsy. Not being able to drive interacts with feelings of dependency and limits on job, school and social activities.

Id. at 48.

¹⁸⁴ Vogtle, *supra* note 12.

¹⁸⁵ *See supra* note 133.

their consequences of little gravity.”¹⁸⁶ As discussed above, the individual interests of autonomy substantially outweigh this unsupported finding, and the negligence theory sufficiently protects the public interest of reducing seizure-related accidents. These factors negate the need for legislation restricting licensure of individuals with epilepsy, especially in view of the absence of restrictions on individuals with similarly debilitating conditions. Therefore, the Bureau of Motor Vehicles should limit the licensing restrictions of individuals with epilepsy to those who pose a significant risk of harm while driving by imposing a nominal time restriction from driving. Moreover, medically cleared individuals with epilepsy should be held to tort negligence.

However, if the Bureau of Motor Vehicles finds that the current driving restrictions on individuals with epilepsy are within the state’s police power and should not be limited, similar driving restrictions should be imposed upon individuals with similar medical conditions in the interest of equity and non-discrimination. There is insufficient medical or scientific evidence to support the notion that individuals with epilepsy are significantly more dangerous while driving than those with similar conditions, and the restrictions expressly targeting individuals with epilepsy are facially discriminatory. Therefore, if the legislature is going to impose driving restrictions on individuals with epilepsy, they must also impose driving restrictions on individuals with other medical conditions that are at a high risk of causing accidents.

¹⁸⁶ Beaussart-Defaye, *supra* note 132.